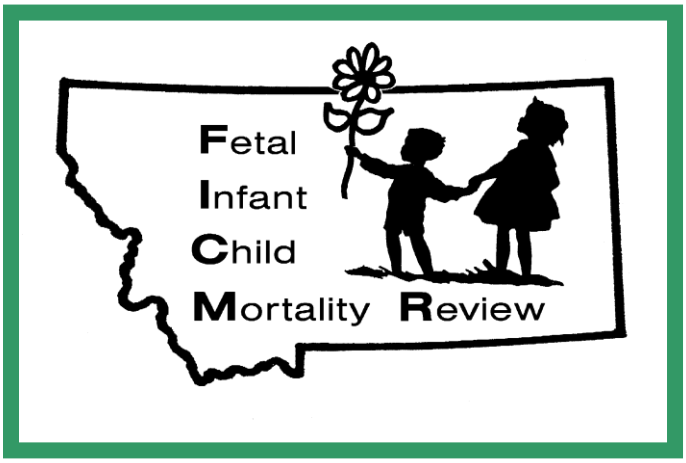

FICMR TRAINING MANUAL

Updated November 2009

MONTANA
Department of Public Health & Human Services

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Introduction

Fetal, Infant and Child Mortality Review (FICMR) program has been active in Montana since May 1997 when HB333, the "Fetal, Infant and Child Mortality Prevention Act" was signed into law. This law (MCA 50-19-401 through 50-19-406) allowed for local FICMR teams to have access to health care and law enforcement information. This law also defined team membership and provided for penalties for unlawful disclosure of confidential information obtained in the review process. This law was revised in 2003. Historically, Fetal and Infant mortality review had been present in Montana counties since 1990, following the passage of the Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) legislation. Child death review followed in 1994 with a pilot project in Missoula County. A multi-disciplinary, multi-agency team was established to programmatically blend the Fetal-Infant mortality review with child mortality review.

Today, twenty-eight local teams review for 56 counties and six tribal governments. In 2005-2006, local teams reviewed 340 (82%) of all fetal, infant and child deaths. The State FICMR multi-disciplinary team remains intact to assist local Montana communities in their efforts of reducing preventable fetal, infant and child deaths.

The original purpose of the FICMR Manual was to assist Montana communities to establish local mortality review teams by providing direction and materials needed for this process. With most local review teams well established in their communities, the focus of this revised manual shifts to serve as an orientation, resource tool for new local coordinators and team members, and it will serve as a reference guide for established teams needing a review.

FICMR Mission Statement

To identify, address and potentially decrease the numbers of preventable fetal, infant and child deaths in the state of Montana

The Fetal, Infant and Child Mortality Prevention Act

The Fetal, Infant and child Mortality Prevention Act ("Act"), was created pursuant to House Bill 333 (HB333) passed during the 1997 Montana Legislative Session. The first six sections of HB 333 constitute the Act, and have been codified as 50-19-401 to -406 MCA. HB 333 also amended existing law to facilitate the Act.

The Act (50-19-402 MCA) statement of policy indicates that "it is the intent of the legislature to encourage local communities to establish voluntary multidisciplinary FICMR teams to study the incidence and causes of fetal, infant and child deaths and make recommendations for community or statewide change, if appropriate, that may help prevent future deaths. Local Public health departments receiving MCH block grant funds are contractually required to "Ensure review and reporting of all fetal, infant and child

deaths occurring in the county jurisdiction by an existing FICMR team-either an internal county team or through written agreement with a neighboring team. (Section 1.A. 11)

Additional References:
41-3-205, MCA (teams may receive child protection records)
44-5-303, MCA (teams may receive criminal justice information)
50-16-525, MCA (teams may receive health care information)
50-19-323, MCA (Coordination of programs with MIAMI)
ARM 16.6.125 (Release of Vital Records to county agencies)

The provisions of the Act:

1. allow teams to access health care information without the need for a signed consent;
2. allow teams to access criminal justice information through the county attorney or a person designated by the county attorney;
3. set out the permissible functions of mortality review teams;
4. set out minimum requirements on membership and management of mortality review reams;
5. provide penalties for the unlawful release of confidential information by members of mortality review teams;
6. mandate that the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) be coordinated with review teams

SECTION 1
GETTING STARTED

The Local Review Team

To be the most effective, a local review team needs the right multidisciplinary membership. MCA 50-19-403 requires that mortality review teams will be multi disciplinary and have at least 5 core members. Core team members are generally professionals who respond to infant/child deaths or are responsible for protecting infant/child health and safety. (CDR manual: p. 18)

Structure of the mortality team will vary in communities depending on the size of the county, resources available and interest of local professionals. Members that are of critical importance to a review team are:

- County coroner or medical examiner
- Physician or nurse practitioner
- Child and Family Services supervisor or social worker
- Public Health Nurse or Social Worker
- Local hospital representative
- Law enforcement officer
- County attorney or designee
- Emergency Medical Responders
- Mental health professional
- Representative of the Tribal Health department or Indian Health Services

Other professionals that enhance a team and are identified in MCA 50-19-403 include:

- Local health department representative
- Representative from a neighboring county or tribal government if there is an agreement to review deaths for that county or tribe
- Representative form department of public health and human services
- Forensic pathologist
- Specialists serving as consultants if not team members: Pediatrician, Neonatologist, Obstetrician,
- Family Practice physician
- Local Trauma coordinators
- Representative of Bureau of Indian Affairs
- Local registrar or clerk and recorder
- Local hospital medical records.

Role of Team Members

Each member of the interdisciplinary team brings a certain level of expertise and experience to the meeting. Roles may overlap with team members having expertise in similar or complementary areas. All team members should serve as liaisons to their private practices, professional organizations and associations.

County Coroner:

- Provides team with status/results of investigation into death and explanation of manner and cause determination
- Provides information on autopsy, toxicology and scene investigation
- Provides groundwork for discussion by providing basic information related to how the death occurred
- Expertise with scene investigation and cause and manner of death

Law Enforcement:

- Provide team with information on the case details and death scene, including arrests or violations
- Provide team with information on any criminal history of family members or suspects
- Provide team with expertise on evidence collection, criminal investigation and death scene investigation
- Assist with facilitating coordination with other law enforcement agencies

County Attorney:

- Provide team with information on status of case being reviewed
- Provide information on criminal and civil action related to the deceased or perpetrator
- Assist team in understanding the legal process and interpreting legal terminology, concepts and practices

Child & Family Services Representative:

- Provide team with information on case status and investigation summary for death being reviewed
- Provide team with information on family and child's history, socio-economic status, family dynamics, previous involvement with CFS, and history of abuse
- Act as liaison to state child protection agency on issues related to child protection
- Provide expertise in abuse and neglect of children
- Expertise on interventions and outcomes of case work with families
- Provide support and case work to surviving siblings and family members

Public Health Nurse:

- Provide information related to contacts make with family, services provided and referrals made
- Provide abstract of medical records including past medical history, history just prior to death, immunization status
- Expertise on prevention and intervention public health services in community
- Expertise in identifying public health issues related to infant and child mortality
- Provide nursing prospective

Medical Doctor:

- Provide team with medical expertise in area of specialty
- Family Practice MD, Obstetrician, Perinatologist, Certified Nurse Midwife provides information regarding normal pregnancy, labor and delivery and interpret case findings with respect to normal pregnancy or delivery. Can also provide team with information on services provided to mother prenatally
- Neonatologist, Perinatologist, Pediatrician, Family Practice MD, Family Nurse Practitioner provides information on services provided to infant or child
- Provide the team with case information and review about expected outcomes, complications of various treatments, and interpretation of case findings in this context

County Registrar/Clerk and Recorder:

- Provide knowledge of vital information: births and deaths, cause and manner of death of county residents and notice of every birth and death in the community
- Provide expertise regarding vital records: data and filing procedures
- Act as liaison with law enforcement, coroner, local morticians and DPHHS Vital Records Bureau

Mental Health Professional:

- Provide information on mental health, chemical dependency and treatment regime related to case
- Provide expertise on psychopathology, psychological issues of child abuse, and mental health treatment modalities
- Provide follow up with surviving siblings and family members

Local FICMR Coordinator:

- Identify deaths in your county or residents of your county who die elsewhere
- Organize and lead local mortality review meetings
- Act as liaison with other community mortality review teams and state agencies

- Develop standards and protocols for local teams as needed
- Educate local agencies and professionals regarding risk factors and prevention activities related to mortality review findings
- Attend state organized FICMR team meetings and trainings and share updates with local team
- In many cases this is also the local Public Health Nurse

School District Representative:

- Provide team with information related to school records of deceased child
- Provide team with information about school policies, programs and resources available to students and families
- Liaison for integrating prevention activities into schools

Emergency Medical Services Representative:

- Provide team with information on details of scene, EMS reports, and information related to Emergency procedures done at the scene
- Provide expertise in EMS procedures and protocols
- Act as liaison between review team and community EMS workers

Tribal Representative:

- Provide team with information about tribal customs and cultural factors
- Provide additional information related to the facts of the case being reviewed.

*The future depends on what we do in the present. – **Mahatma Gandhi***

LOCAL FICMR TEAM MEMBER PARTICIPATION RESPONSIBILITIES

1. Commitment to Participate.

- **Meeting attendance.** Team members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. If a team member is not able to attend a meeting the local coordinator should be notified in advance. If attendance becomes problematic, the team member should provide an alternate or perhaps find a like skilled replacement
- **Active Contribution to case discussions.** A thorough and comprehensive discussion is necessary for all reviews of fetal, infant and child deaths, requiring the full participation of each team member
- **Familiarization with the FICMR Report tool.** In order to enhance participation in case discussions, team members should become familiar with the required data elements in the data collection tool.

2. Case discussions: Preparation and Participation

- **Review of case records prior to the review.** Each team member should perform a complete review of his or her agency/practice records for information pertinent to each case to be reviewed. **Case files may be brought to review meetings for reference, but should not be copied for distribution to other team members.** Any written notification from the coordinator of the cases to be reviewed should be destroyed or returned to the coordinator at the time of the review for shredding.
- **Contribution of information from case records.** If any team member(s) feel that he or she cannot discuss the details of a case openly at the time of review, that team member(s) should inform the coordinator so that the review can be postponed.

3. Provisions of individual and agency perspective, including policies and procedures.

- Each of the core team members has a specific and critical role in the review process. The FICMR team is a multi-disciplinary group composed of representatives with a broad range of training and expertise. The FICMR process does not duplicate the data collection, analysis processes or investigative roles of any single participating agency.

4. Coordination and communication with participating agency representatives and private practitioners.

- Members should serve as liaisons to their respective professional counterparts. Case reviews provide opportunities for inter-agency and cross-disciplinary collaboration.

5. Maintenance of confidentiality (See also Section 3-Confidentiality)

- The Fetal, Infant and Child Mortality Prevention Act (50-19-404 to 406, MCA) provides for protection of the confidentiality of the review process and penalties for members of teams who unlawfully disclose information from case reviews. FICMR teams do not conduct peer reviews. Medical providers' names should not be used in association with any review.
- **All members must sign a confidentiality statement each year.** Team members cannot disclose any information discussed during a review, except within the mandates of their agencies responsibilities.
- **No identifying materials may be taken from a meeting by persons other than those whose agency or practice provided the information.**
- **Local FICMR meetings are closed to all others except team membership.** No students or other visitors shall be allowed to attend case reviews. Teams *may not* invite "experts" to participate in specific case reviews, but are encouraged to recruit members with the expertise and qualifications to address a broad spectrum of issues. All in attendance must be team members so they are subject to the conditions of confidentiality specified in the FICMR statute.

Maintain Confidentiality

Keep it zipped.

SECTION 2
THE MORTALITY REVIEW PROCESS

Steps to the Mortality Review process—"Where do I start?"

The death of an infant or child is a sentinel event that can identify potential risks to other children. Mortality review teams' primary goal is prevention and the more cases reviewed the better. It is most effective to have a comprehensive system in place to identify all the fetal, infant and child deaths within a given time period.

Find the deaths in your county.

- Establish connections with the registrar/clerk and recorder. This person may be a FICMR team member, which may help him/her feel more connected to the process.
- Call the registrar monthly regarding deaths or ask that the registrar notify you of any fetal, infant or child deaths that occur.
- Review the Quarterly FICMR Vital Statistics log. This is sent electronically every quarter by the DPHHS FICMR Coordinator. Deaths are listed by county of residence. Be sure to also check the end of the report for deaths of non-Montana residents who died in your county.
- Read the death/funeral notices in the local paper.
- Establish relationship with the local hospital nurse case managers or social workers who coordinate care for families, so when a death occurs at that facility you can receive notification timely.
- It may be helpful to create a list of deaths you need to review. This should be a sequential record that includes the name, date of death, age, sex, cause and manner of death. You can then compare this list to the registrar's list and the Vital statistics log to insure that all deaths are reviewed.

Determining which County will complete review if death occurred outside of residing county. In most cases the death occurs in the infant/child's county of residence, but occasionally the death occurs in a different county. The factors in each case will help determine which county will do the review. Here are some scenarios that will help clarify which county should complete the review.

- If a fetal death or death of an infant born prematurely occurs in your county because mom was sent to your hospital, the county of Mother's residence should be completing the review. (That was where the pregnancy progressed) The county where the death occurred would be able to help obtaining hospital records.
- If teens left their county of residence and were involved in a motor vehicle fatality in a different county, the county of death would do the review. This would allow for local review and prevention actions.
- If those same teens were also intoxicated, perhaps both counties would want to collaborate on the review (Residing county to determine how they got the alcohol and the county of death to review the factors of the accident)

Prepare for the review team meeting.

- Obtain the death certificates.
- Notify team members of the FICMR meeting date. Advise them which cases (names) you will be reviewing so that they can obtain and prepare complete information. You may do this hard copy or electronically—following the confidentiality guidelines.
- *Case reviews are only effective if team members *show up* for meetings and *bring pertinent information* with them.
- Abstract medical records and gather information about the death. It might be helpful to make a list of the information you need from the medical records so you get all information needed. In many cases the medical records are incomplete shortly after the death because of pending autopsy, toxicology or tissue analysis reports. *It might take three months or longer before records are available.* It is fine to delay the review until you have all pertinent records. Write a brief summary to present to your team at the meeting.
- Complete as much of the review tool as possible before the meeting so that you can educate the team about the death and guide the discussion.
- Consider conducting a home interview of family of the deceased child. This allows for information gathering as well as your opportunity to see how the family is handling the loss. You may approach this on a case by case basis. (See appendix A—mortality home visits). Here are some comments from Montana Local FICMR coordinators regarding home visits after loss of child:

    - "I frequently make phone calls and ask questions and that seems to be just fine with family. They rarely if ever ask why I am reviewing their child's death. Usually they are happy to tell me what I need to know. I think that by calling instead of home visiting, I am giving them the opportunity to talk without invading their space."
    - "I always try to make a home visit for an infant death. For child deaths it depends on the circumstances and my prior involvement with child or family. For fetal deaths I usually see them at WIC appointments, but generally do not schedule specific home visit."
    - "Home Visits are done on a case by case basis. They are offered to all (not just PH clients) if it seems appropriate. Usually they are not wanted, so are seldom made."
    - "Various team members usually have some contact with family members (through WIC, public health, doctor's appointment, PHN visiting the home for some other reason) and we use information gleaned from those interactions to give us a fuller picture of the circumstances surrounding the death."
    - "We visit with the moms as part of MCH or WIC just to offer support etc but not to go into detail about the death itself."
    - "Some families decline, others cannot be reached by phone, others do not respond to a letter. It is easier if the family has been involved in PHHV program, but I do contact all SIDS."

FICMR Review Meeting

- You must have five (5) team members present for a review.
- Coroner or his written report is vital for the review of an infant or child.
- Each team member presents information related to their discipline about the deceased infant or child to the group. (Law enforcement would present the police report of the accident, Child and Family services would provide any case information of their interaction with family)
- ***Share, Question, Clarify**—the goal here is to make sure everyone understands all of the circumstances leading up to the death. The floor is open for discussion—the FICMR leader may take notes of issues raised.
- Obtain team consensus on questions. Decision does not have to be unanimous—majority rules. FICMR leader can fill out the review tool as decisions are made.
- The Tool is a work in progress—if the team changes their decisions after a response is entered—correct it. **Just make sure that the response you want is evident and legible.**
- No note taking by team members during meeting. Team members may only take documents and papers they brought into the meeting. Collect and shred all other information at the end of the meeting.
- Establish **preventability.** (Section I, questions 1&2 FICMR tool). Be sure to consider any potential behaviors that could increase the risk. It is okay to use "Cannot be determined" if the team feels risk factors may have contributed to death, but can not say for sure.
- Discuss and determine who will be responsible for taking preventability to action.

After the Meeting

- Send completed FICMR review tool to DPHHS FICMR Coordinator as soon as possible following the meeting. Your reviews are monitored quarterly, so please do not hold them for quarterly or annual submission. Reviews are due by 12-31 of the year following the death. (per MCH contract-APPENDIX-B) Timely completion and submission is appreciated.
- Keep a copy of the tool (if feasible) and your notes in a locked file. This is helpful if questions were overlooked and DPHHS coordinator has questions for data entry. Retain records and notes until the biannual report is published then you may shred.
- See to it that prevention activities get initiated and have follow up

Timing of Reviews

The frequency and schedule of FICMR reviews will depend in part on how many deaths occur in your county. In communities with few deaths, your team may only meet as needed, quarterly or biannually. In larger communities or areas that have more deaths to review, it may be feasible to hold monthly meetings to ensure all reviews are completed in a timely fashion.

Deaths should be reviewed no later than the end of the calendar year following the death. (Example-for a death occurring 10-24-2008 the death should be reviewed no later

than 12-31-09). However, any death under **criminal investigation or pending litigation should not be reviewed until the case has been resolved by the legal system.** In these cases, please notify the DPHHS FICMR coordinator that this case is pending litigation or under investigation.

For most straightforward cases, you should be able to complete the review with in 6 months of the death.

Definitions:

- **Fetal death-** birth of a fetus without any signs of life that weighs at least 350 grams or if the weight is unknown has reached 20 weeks of gestation.

- **Infant death-**(from Montana Vital Statistics) – death of "an individual less than 365 days (one year) old." *Keep in mind that if the baby shows any sign of life at birth-**regardless of gestational age or weight**—a birth certificate will be issued. The deaths of these infants are considered "infant" death as opposed to fetal death and do require a review*

- **Child death**- death of an individual between the age of 1 year through the end of 17th year.

Preventability

The definition of preventability for local review teams is as follows:

> *"A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention (e.g. medical, educational, social legal or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available."*

Local teams must support the determination of a preventable death with an explanation, and provide recommendations for prevention of similar deaths. (See section I Prevention and Team Findings—review tool)

1. Questions for the team to consider in the determination of preventability:

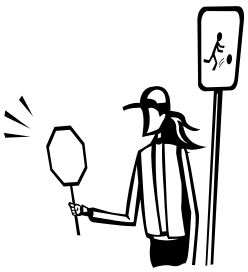
   - What factors contributed to this death? e.g. substance abuse by caretaker or child, lack of safety restraints, depression, inappropriate health care or treatment
   - Were there issues that related to service delivery or access?
   - Were all appropriate actions taken?

2. Determining the degree of preventability. After completing the review the team will need to decide if the death was:
    - "not at all preventable"
    - "definitely preventable"
    - "preventability can not be determined"

    A written explanation must accompany the determination. It is important for the team to consider the presence of modifiable risk factors when determining preventability.

3. Identifying Modifiable Risk Factors: An important step in prevention is to know what modifiable risk factors are present. Once the team has identified the risk factors present, the team should decide which factors they can modify and how the change can best be done. Some examples of modifiable risk factors include (but are not limited too):
    - Behavioral—smoking/drug use during pregnancy, not wearing seat belt, drinking and driving, risky behavior
    - Environmental—exposure to second hand smoke, unsafe sleeping environment, easy access to firearms/drugs/medication/poison
    - Economic—lack of proper crib/bed for infant, financial inability to obtain smoke detector/batteries

Examples of Preventable deaths	Preventable prematurity Intentional and non-intentional injuries Fatal injuries sustained in motor vehicle accidents without use of safety belts or seats. Lack of access to medical care leading to a fatality Neglect and reckless conduct by professionals (including religious and medical)
Examples of Indeterminate deaths "preventability could not be determined"	Any death in which the FICMR team is presented with complete information but is still unable to determine preventability. For example, infant born extremely prematurely and not viable, but mother smoked during pregnancy. (Could smoking have caused the preterm delivery?)
Examples of non-preventable deaths	Terminal medical conditions Lethal anomalies Fatal injuries sustained in course of natural disaster Unforeseen medical complications leading to death



SECTION 3
CONFIDENTIALITY

Confidentiality Guidelines

Teams must adhere to protocols for the preservation of confidentiality in the mortality review process. All necessary precautions should be taken to assure the integrity of the team's proceedings. The confidentiality of the mortality review process is defined in MCA 50-19-404.

> **50-19-404. Records -- confidentiality.** Material and information obtained by a local fetal, infant, and child mortality review team are not subject to disclosure under the public records law. Material and information obtained by a local fetal, infant, and child mortality review team are not subject to subpoena.
>
> **History:** En. Sec. 4, Ch. 519, L. 1997; amd. Sec. 3, Ch. 413, L. 2003.

MCA 50-19-405/406 cover penalty for unauthorized disclosures.

> **50-19-405. Unauthorized disclosure -- civil penalty.** A person aggrieved by the use of information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or by a disclosure of that information in violation of 50-19-402(2) may bring a civil action in the district court of the county of the person's residence for damages, costs, and fees as provided in 50-16-553(6) through (8) or 50-16-817.
>
> **History:** En. Sec. 5, Ch. 519, L. 1997; amd. Sec. 12, Ch. 396, L. 2003; amd. Sec. 4, Ch. 413, L. 2003.

> **50-19-406. Unauthorized disclosure -- misdemeanor.** A person who knowingly uses information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or who discloses that information in violation of 50-19-402(2) is guilty of a misdemeanor and upon conviction is punishable as provided in 46-18-212.
>
> **History:** En. Sec. 6, Ch. 519, L. 1997; amd. Sec. 13, Ch. 396, L. 2003; amd. Sec. 5, Ch. 413, L. 2003.

Guidelines for Consideration:

Information that must be held confidential includes but is not limited to:

- Personal identifiers—names, addresses
- Social/economic situation of the family
- Agency involvement and services provided
- Medical histories of the deceased child or family member
- Identification of care providers and institutions

Data Collection, Storage and Dissemination:

- Remove personal identifiers, assign case numbers
- All records should be stored in a secure area-locked file with limited access
- No reports of files with identifying information should be photocopied, duplicated or transcribed to another source

Review-Team Meetings:

- Closed meetings—only team members may attend meetings. Persons, who have specialty training and would be helpful during review, should be invited to be a team member providing that person meets the criteria outlined in MCA 50-19-403 subsection 2.
- Reinforce and review confidentiality protocols with team members in writing
- Each team member must sign a confidentiality statement annually—Some teams include the confidentiality statement on the meeting sign in sheet as a reminder.
- No case information or details regarding discussion of cases should be shared outside of review meetings. (Releasing case specific information that is not public record would be a serious breach of confidentiality)
- Recommend that team members share information verbally rather than distributing copies of records

Records currently available to mortality review teams in Montana are:

- Medical records, including Emergency Room reports, hospital records, physician records, Emergency Medical Services/ambulance records
- Child and Family Services Division case records
- Vital records-death certificates
    - As of October 1, 1999, Montana Death Certificates became public record. (MCA 50-15-121)
    - FICMR teams must still follow all confidentiality guidelines
    - Death certificates should be available within ten days following the death…unless there are extenuating tests (toxicology)
    - Electronic files—all death certificates can be accessed by local clerk and recorders.
    - FETAL Death Certificates—State FICMR coordinator will have copies of all fetal death certificates for deaths occurring 1-1-2008 or after. These death certificates can also be obtained thru the clerk and recorder but do not include the medical information found on the complete copy available from State FICMR Coordinator.
    - Parents can request a Certificate of Still birth for fetal death occurring at or after 20 weeks gestation.
    - For questions regarding vital records contact State FICMR coordinator or James Edgar, Office of Vital Statistics 444-4250 or jaedgar@mt.gov
- Out of State death certificates-The Office of Vital statistics does receive copies of Montana resident death certificates from some other states under an interstate

exchange agreement. Information from these certificates is available by contacting state FICMR coordinator.

SECTION 4
SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a *complete autopsy, examination of the death scene*, and *review of the clinical history*.

According to the Center's for Disease Control (CDC) website, SIDS is the leading cause of death among infants through their first year of life and is the third leading cause of death for infants in the United States.

Nationally Recognized Major Risk Factors for SIDS

- Infants sleeping on their stomachs.
- Soft infant sleep surfaces and loose bedding.
- Maternal smoking during pregnancy.
- Second-hand smoke exposure.
- Overheating.
- Prematurity and/or low birth weight.
- Infants that share a bed with others.
- Place and position where child was sleeping or playing.
- Type of bedding, blankets and other objects near child.
- Faulty design of cribs or beds.
- Number of and ages of persons sleeping with child.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with child.
- Quality of supervision at time of death.
- Family's ability to provide safe sleep or play environment for child.

Resource: National MCH Center for Child Death Review.

Records Needed for Case Review The following information is very helpful for Mortality review teams when performing a death review.

- Autopsy reports
- Scene investigation reports and photos
- Prenatal, birth and health records
- Interviews with family members
- Day Care Licensing investigative reports
- EMS run reports
- Emergency Department reports

- Prior CPS history on child, caregivers and person supervising child at time of death
- Criminal background checks on person supervising the child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family

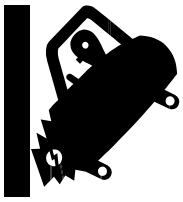
Evidence Based Best Practices for Prevention. Prevention activities aimed at reducing the presence of risk factors for SIDS continue to be a public health priority and include:

- Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
- In-hospital assessments by nurses with parents to assess a baby's sleep environment when it goes home.
- Crib distribution programs for families.
- Smoking cessation education and support for pregnant and parenting women and other caregivers.
- Working with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established.
- The "Back to Sleep" campaign.
- Specific messages targeted to families and childcare providers who traditionally practice stomach sleep positions.
- Education to health care providers on giving guidance on SIDS risk reduction to parents and caregivers.
- Licensing requirements for daycare providers on safe sleep environments and infant sleep positions

Resource: National MCH Center for Child Death Review.

Other Resources for SIDS and Safe Sleep

- DHHS, NIH http://www.nichd.nih.gov/publications/pubs/upload/bts_safe_environment.pdf
- Medline plus http://www.nlm.nih.gov/medlineplus/suddeninfantdeathsyndrome.html
- First Candle http://www.firstcandle.org/
- American Academy of Pediatrics http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf



SECTION 5

MOTOR VEHICLE DEATHS

In 2005-2006, Local FICMR teams reviewed 40 motor vehicle related deaths. Thirty-eight of those deaths were to children aged 1-17. This was the second most common cause of death to this age group during that time.

Major Risk Factors

Children Under 16

- Not using or improper use of child restraints, including seatbelts, infant and booster seats.
- Not wearing adequate safety equipment, especially helmets for motorcycles, bicycles and all-terrain vehicles.
- Riding in truck beds or other unrestrained areas of motor vehicles.
- Unskilled or unsupervised drivers of recreational vehicles, including snowmobiles, jet skis, all terrain vehicles, go-carts and dirt bikes.
- Riding in the front seat of vehicles.
- Small children playing in and around vehicles or crossing streets without supervision.

Children Over 16

- New driver inexperience and/or recklessness.
- Riding in a car with two or more teen passengers.
- Exceeding safe speeds for driving conditions.
- Not using appropriate restraints.
- Riding in a car as a passenger with a new teen driver.
- Using alcohol while driving, or riding with someone who is under the influence of alcohol.
- Driving between 12 midnight and 6:00 a.m.
- Riding in the bed of a pickup truck.

Resource: National MCH Center for Child Death Review.

Records Needed at Review: The follow information is very helpful for mortality review teams when review a death.

- Autopsy reports
- Scene investigation/police reports and photos
- EMS run reports/Emergency Department reports
- Blood alcohol /toxicology screens for driver and victim
- Previous violations of driver(s)
- Information of history of crashes at same site

Evidenced-based practices for Prevention

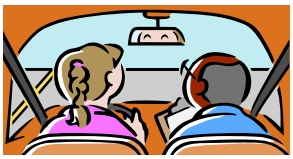
Children Under 16

- Lower Anchors and Tethers for Children (LATCH): USDOT requires all new child safety seats meet stricter head protection standards.
- Education to increase booster seat usage for children between 40 and 80 pounds.
- Child Safety Seat Inspection Programs
- Free or low-cost car seat distribution.
- Bicycle Helmet Laws and offer free or reduced-cost helmets to children.
- Truck Bed Law prohibiting children from riding in truck beds and KIDS AREN'T CARGO is an education campaign discouraging truck bed riding.
- Re-engineer roads and improve signage.

Children Over 16

- Graduated Licensing Laws: including supervised practice; crash and conviction free requirements for a minimum of six months; limits on number of teen passengers; nighttime driving restrictions and mandatory seat belt use for all occupants.
- Driver's Education: Customize local programs to emphasize most common risk factors, e.g., off-road recovery on gravel roads in rural communities.
- Seat Belts: Education to increase adolescent seat belt use and primary seat belt enforcement laws.
- Re-engineer roads and improve signage.
- Eliminate driving under the influence of drugs or alcohol.

Resource: National MCH Center for Child Death Review



SECTION 6

SHAKEN BABY SYNDROME

What is Shaken Baby Syndrome?

Shaken baby syndrome is a type of inflicted traumatic brain injury that happens when a baby is violently shaken. A baby has weak neck muscles and a large, heavy head. Shaking makes the fragile brain bounce back and forth inside the skull and causes bruising, swelling, and bleeding, which can lead to permanent, severe brain damage or death. The characteristic injuries of shaken baby syndrome are subdural hemorrhages (bleeding in the brain), retinal hemorrhages (bleeding in the retina), damage to the spinal cord and neck, and fractures of the ribs and bones. These injuries may not be immediately noticeable. Symptoms of shaken baby syndrome include extreme irritability, lethargy, poor feeding, breathing problems, convulsions, vomiting, and pale or bluish skin. Shaken baby injuries usually occur in children younger than 2 years old, but may be seen in children up to the age of 5. (National Institutes of Health)

The trigger is usually inconsolable crying by the baby. The parent or caregiver, in frustration or anger, violently shakes the baby in an effort to get him to stop crying.

Prevention:

Prevention of Shaken Baby Syndrome is really geared toward calming a crying infant and helping parents and caregivers recognize their own stress levels.

Ways to Soothe or Calm a Crying Baby:

- Start by making sure basic needs are met—clean diaper, food, appropriate clothing
- Try a pacifier
- Take baby for a walk—use stroller, front pack (“Snuggly”) body carrier
- Place baby in car seat and go for a drive
- Call a trusted friend, family member or neighbor to come for support—this person could take care of the baby while you take a little break
- Place baby in safe place (crib or playpen) and give yourself a time out. Check on baby every 5 minutes

- Take 10 deep slow breaths…then take 10 more
- Gently rock the baby or sway side to side—Hum or sing to baby
- Try using "white noise" from a recording or run the vacuum cleaner or clothes dryer
- **Never SHAKE a baby.**

Resources for Shaken Baby Syndrome or Calming a Crying Baby:

National Center on Shaken Baby Syndrome www.dontshake.com

Kids Health-Abusive Head Trauma
http://kidshealth.org/parent/medical/brain/shaken.html

Montana Child Abuse Hotline: **1-866-820-5437**
(toll free, 24 hours)

SECTION 7

GRIEF SUPPORT AND COUNSELING

Grief is a normal response to loss. Parents who experience a pregnancy loss or the death of an infant or child will also experience grief. The Public Health Home Visitor's response to a grieving family can greatly affect how that family recovers from the loss of their infant or child. The family can benefit from clear concise information and support.

The Grieving Process:

- Grief is a personal response. Not everyone responds the same way to a loss. There is not a right or wrong way to grief.
- The grieving process takes time…some people are able to get through their grief quickly and others take a longer time.
- The Public Health Nurse or FICMR coordinator can acknowledge and validate the family's loss and grief. Offer support to the mother or family and let them show you what they need.
- Kubler-Ross's 5 stages of grief—Denial, Anger, Bargaining, Depression and Acceptance—It is important for the professional to keep in mind that each stage can last a different length of time and some people don't go through each stage.
    - It can be reassuring for the grieving family to know that their feelings or reactions are normal.
    - However, keep in mind that it is possible to not experience any of the stages during the healing process.

Ways to support the grieving mother and/or family.

- Encourage good self care
    - Eat healthy foods, avoid alcohol and caffeine
    - Try to be active every day. Go outside, take a walk
    - Stick to you daily routine, get up and go to sleep at the same time.
    - ***http://www.helpguide.org/mental/grief_loss.htm***

- Encourage her to share her feelings
    - Encourage her to talk about her baby/child with her partner or family and friends. Share feelings with them.
    - ***http://www.marchofdimes.com/pnhec/572_4047.asp***
    - ***http://www.marchofdimes.com/professionals/572_4049.asp***
      http://www.firstcandle.org/whenababy_stillbirth/stillbirth_grief.html

SECTION 8

SUICIDE PREVENTION

Nationally Recognized Major Suicide Risk Factors

- Long term or serious depression
- Previous suicide attempt
- Mood disorders and mental illness
- Substance abuse
- Childhood maltreatment
- Parental separation or divorce
- Inappropriate access to firearms
- Interpersonal conflicts or losses without social support
- Previous suicide by a relative or close friend
- Other significant struggles such as bullying or issues of sexuality
- Isolation

Evidence Based Best Practices for Prevention

- The Yellow Ribbon Suicide Prevention Campaign to help youths identify places to get help when they or their friends are troubled
- School gatekeeper training to help staff identify and refer students at risk
- Community gatekeeper/suicide risk assessment training for community members who interact frequently with teens
- General suicide education targeted to teens to help understand warning signs and support services
- Screening programs, including those in schools, to identify students with problems that could be related to potential suicide
- Peer support programs that foster positive peer relationships and competency in social skills among high risk adolescents and young adults
- Crisis centers and hot lines
- Restriction of access to lethal means of suicide including gun locks and removal of firearms in homes of high risk teens
- Interventions after a suicide that focus on friends and relatives to help prevent or contain clusters and to help the adolescents and young adults cope effectively with the feelings of loss/ guilt that follow a suicide
- Development of assessment tools for evaluating suicide risk for students who are expelled from school or arrested for minor offenses

References: National MCH Center for Child Death Review; Harborview Injury Prevention and Research Center

Suicide Prevention Resources

Montana Resources:

American Federation for Suicide Prevention, Montana Chapter
www.afspmontana.org

Montana Strategic Suicide Prevention Plan
http://www.dphhs.mt.gov/amdd/statesuicideplan.pdf

Montana Wyoming Tribal Leaders Council
Planting the Seeds of Hope
www.mtwytlc.com/plantingseedsofhope.htm

Surviving Our Loss after Suicide
www.suicide-montana.org

National Resources:

American Academy of Child & Adolescent Psychiatry (AACAP)
www.aacap.org
Children's Safety Network
www.childrenssafetynetwork.org

National Center for Injury Prevention and Control
www.cdc.gov/ncipc

National Center for Suicide Prevention Training
www.ncspt.org

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Association
www.nmha.org

National Strategy for Suicide Prevention
www.mentalhealth.org/suicideprevention

Suicide Information & Education Center (SIEC)
www.siec.ca

Suicide Prevention Advocacy Network (SPAN)
www.spanusa.org

Suicide Prevention Resource Center
www.sprc.org

APPENDICIES

APPENDIX A

Mortality Home Visit

Contacting parents who have suffered a pregnancy loss or the death of an infant or child can at times be difficult for public health nurses. Many nurses have expressed discomfort related to approaching grieving parents to request home interviews. Mortality home visits can be informative and can be used on a case by case basis.

A home interview with families who have had a pregnancy loss or the death of an infant or child can give validity to the loss. Many hospital social workers and nurse case managers offer grief support and referrals for families whose children have died in their facilities. The death of an infant or child or loss of a pregnancy can provide an opportunity for collaboration by hospitals and public health departments to provide continuity of support to grieving families.

Mortality Home Visit Approaches

Early contact Approach:

- Home Visit occurs within few days or week of death. This might be a telephone call or face-to-face visit. The main purpose of the visit is to establish relationship with family and offer support, reassurance and any needed referrals. The PHN would want to express sincere compassion for the loss of the child.
- The PHN may also choose to introduce the subject of a follow up visit in a month to discuss how the family is coping and to discern information about the death.
- The second piece of the visit—information gathering could also be presented at this time depending on the PHN's assessment.

Standard Approach:

- Families who have experienced a pregnancy loss or death of an infant or child, may be sent a letter telling them of the FICMR review process and letting them know of your interest in an interview to be scheduled 1-3 months after the death (or at mother's preference)
- Mother or family is contacted by telephone to ascertain how the family is doing and to explain any questions about the interview process.
- Interview can occur over the phone or in person.

Questions that may facilitate your interview:

- "Tell me what happened to (refer to the baby/child by name if given)?"
- "How was the baby's death explained?"

- Ask parents to describe their understanding of events leading to the death and the cause of death. Hearing their interpretation of what caused the death will help you assess their need for education and support.
- Be sure to ask about the family members' health and coping since the death. This includes parents and siblings—how are they sleeping, appetite, school performance and behavior, emotional state.

Dealing with refusals for home visit:

- Explain that the information gathered from the interview will be used to look at prenatal and child health resources and services in the community to find ways to help families like theirs in the future.
- Encourage to your comfort level, always keeping in mind the sensitive nature of the home interview.
- If a mother refuses, offer condolences and ask if you could call back in a month to see how she is doing or provide your contact information and encourage her to contact you for support.

Reference: "A Guide for Communities." Fetal and Infant Mortality review Manual, 2nd Ed. ACOG. Washington, DC. 2008.

APPENDIX B

11. **Does your County comply with statute Montana Code Annotated (MCA) 50-19-401 through 406, which oversee the Fetal, Infant and Child Mortality Prevention Act (FICMR)?**

☐ Yes
☐ No

The MCA for the Fetal, Infant and Child Mortality Prevention Act is located at http://data.opi.state.mt.us/bills/mca_toc/50_19_4.htm

12. **Who conducts your County's FICMR reviews?**

☐ Your county team (internally)
☐ A neighboring county team or partner county:

_____
Name of County

☐ FICMR reviews are not being conducted

Calendar Year – January 1, 2009 to December 31, 2009

	Number of deaths	Number of deaths reviewed	Number of Reviews Submitted to State FICMR Program
Fetal Deaths			
Infant Deaths			
Child Deaths			

What prevention activities has your County implemented? *(Please provide at least 1 and up to 3 examples)*

1. _____

2. _____

3. _____

APPENDIX C

FICMR Review Checklist	
Before meeting	
	Determine deaths in your community
	Obtain Death Certificates
	• Infant/Child from local Registrar or Clerk and Recorder
	• Fetal from local Registrar or State DPHHS FICMR coordinator
	Review Quarterly FICMR Spreadsheet
	• Check county of residence and county of death columns
	Gather Medical Information
	Abstract Medical Records-gather info about death
	Review death certificate—especially fetal as contains good info
	Brief summary for team meeting
	Notify local FICMR members of date/time and which cases are to be reviewed
	FICMR Review tool—fill out as much as possible before meeting
During Meeting	
	Review /Sign Confidentiality
	Finish Completing tool—get consensus on team decisions—majority rules
	Preventability Does team feel death was preventable or not or are they not sure?
	If Preventability could not be determined—list conflicting factors that prevented a decision.(It is okay if you cannot determine!!)
	For preventable deaths, what is your action? This can be continuation of current program or implementation of new. Please list on Review form
After Meeting	
	Once tool is complete send to DPHHS FICMR Coordinator
	Keep your records /copy of tool (optional) in a secure locked location
	Records may be shredded after state report printed.

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